

Racism, Discrimination and health services to Aboriginal people in South West Queensland

ABSTRACT

Social justice from an Aboriginal perspective is about treating everyone affordably with the same rights, access and opportunities, showing respect and embracing all cultures within the community. It is essential that services and organisations create an opportunity for Aboriginal and Torres Strait Islander culture and practices to be acknowledged and embedded into planning and delivery of effective and efficient services. This would enable a more client-friendly and culturally appropriate service that Aboriginal and Torres Strait Islander people could access. Research indicates that Aboriginal people who have access to services that are culturally sensitive, close to where they live, staffed by Aboriginal health professionals, non-racist, where people are acknowledged as true owners of their land and culture, and where beliefs and traditions are respected and accepted would have healthier communities. In light of the above, research was undertaken to explore and identify the different types of health and counselling services in a rural and remote community in South West Queensland. The methodology used for this research integrated both a quantitative and qualitative approach, researching the services that existed through focus groups. There were a total of twenty-seven (27) participants recruited for the research. From the data collected and analysed the themes identified were: racism and discrimination, beliefs, attitudes and misconceptions, leadership, and culture. For the purpose of this paper racism and discrimination will be discussed in relation to health service provision.

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INTRODUCTION

Aboriginal people have been disadvantaged socially, educationally and economically (Kahn et al 1978) since 1788 and continually face these problems within today's society. While the persistence of traditional practices and extended family systems have formed the basis for resiliency within Aboriginal communities there have been important and pervasive cultural changes affecting families, children and youth, and, with them, exposure to domestic violence, substance misuse, suicide and self harm, and other sources of risk (Cooperative Research Centre for Aboriginal Health 2006). Impacts of colonisation upon Aboriginal people and the effects on their health and social and emotional wellbeing is continually reiterated in research articles and studies (Radford 1999; Blum & Harmon 1992 & Australian Institute of Health and Welfare 2002) including the dispute that services are not being accessed at a level which equates to this need (Westerman 2004; Garvey 2000 & Vicary 2002). As a consequence of colonisation, Aboriginal and Torres Strait Islander people and communities experienced social and cultural break down. In their efforts to change this, government welfare policies made many Aboriginal and Torres Strait Islander people and communities welfare dependant and caught in a cycle of poverty. From an Aboriginal perspective, social and emotional well-being problems can result from: grief; loss; trauma; abuse; violence; substance misuse; physical health problems; child development problems; gender identity issues; child removals; incarceration; family breakdown; cultural dislocation; racism; and social disadvantage (Aboriginal & Torres Strait Islander Health Performance Framework Report 2006). The very high death rates of Aboriginal and Torres Strait Islander peoples in their middle adult years deprive Aboriginal and Torres Strait Islander people of husbands, wives, parents and grandparents. The high levels of binge drinking cause serious damage to not only the drinkers, but their families and wider communities. The high levels of mental illness, of substance abuse, and suicide all testify to the challenges faced by Aboriginal and Torres Strait Islander peoples. The financial stress in which the majority of Aboriginal and Torres Strait Islander households survive indicates not only that they are severely limited in their ability to cope with a crisis, but also unable to accumulate resources (Mouse 2004). Aboriginal and Torres Strait Islander people have higher rates of suicides, are hospitalised at higher rates for intentional self-harm and have little access to limited education on how to deal with mental health crises as well as managing mental health problems. Swan and Raphael (1995) recommended that Aboriginal and Torres Strait Islander mental health strategies need to provide community people with programs of how to

recognise respond and prevent mental health problems and suicidal behaviours. Aboriginal & Torres Strait Islander people are more likely to access mainstream services in the event of a crisis instead of other community based services, which are unevenly and poorly distributed in rural and remote settings. Access to health services, the ability to act on health advice, and the capacity to modify health risk factors are all influenced by the circumstances in which people live and work. Studies have shown that those most needing care are least likely to receive it (Harper et al 2004).

METHODOLOGY

Design

A research proposal was developed and submitted to the University of Southern Queensland Ethics Committee at the end of 2008 with approval given in 2009 to commence the research. The early stages of the research undertook an analysis of the Dalby community to identify parameters for the research in line with identified objectives. The methodology used for this research, integrated a quantitative and qualitative focus, researching the types of health and counselling services existing through focus groups.

How was the research carried out?

Throughout the research process a set of Indigenous protocols for engagement and consultation (keeping research on track: a guide for Aboriginal and Torres Strait Islander people's about health research ethics) were put into practice. (http://www.nhmrc.gov.au/files_nhmrc/file/publications/synopses/e65.pdf) Implementation of the non-Indigenous academic research process and the Indigenous research process were done simultaneously, to further develop and build a rapport with Aboriginal people and non-Indigenous people while establishing and maintaining relationships before, during and after the research journey. For the purposes of this research, face to face interviews, focus groups and attendance at community meetings were conducted, in conjunction with any health promotion and educational programs being delivered within the community. There were two groups of participants to consider in undertaking this research, the first group were health and counselling services and the second group were the Aboriginal population. The process for identifying and gathering information about health and counselling services occurred through researching local and regional resources, databases, internet sources and other identified sources. A total of thirty six (36) individual services were identified as providing health and counselling services across the community. The major services that Aboriginal people

utilised regularly were; the local hospital, Aboriginal Medical Service and in particular, the counselling services provided under the 'Bringing Them Home' initiative.

Recruitment of participants

Identifying and recruiting Aboriginal participants occurred through networking and liaising with local Aboriginal services in the community as well as mainstream organisations. A set of criteria were developed for recruitment purposes including details of information sessions for the recruitment of participants which were published in a local paper. Information sessions were held in the community at a central location giving participants easy access. These sessions were held on consecutive days at the same time during the morning for convenience. Catering, transport and child-care arrangements were prearranged for participants. Content of the information sessions covered all aspects of the research background information; reason behind the research; how the research would be rolled out; risk and benefits for the community and how community could become involved. Written consent was sought from all participants and copies given to them.

Data Collection

Data was collected via focus groups. The purpose of the focus groups was to understand how people felt or thought about the issues, products, or services. Within the community four (4) focus groups were established which assisted in drawing out knowledge, experiences and feedback from participants and communities (Grbich, C. 1999 p. 108-114).

FINDINGS

Profile of Participants

The majority of the participants, except for three, identified as Aboriginal and living in the community. Non-Aboriginal participants worked for Aboriginal and Torres Strait Islander services locally. Of the 27 participants the majority were female (21). Ages varied from 20 years up to 70 years of age. All of the participants had lived in the community as a child and had recently moved back as an adult. Thirteen participants stated that they were employed and the other 14 stated they were unemployed. Three participants stated they were stay at home mums. The majority of the participants had connections within the community (family, friends etc) both past and present. Across the focus groups participants had seen a number of changes occurring within the community regardless of their length of time as residents.

THEMES

A thematic analysis of the information gained from the focus groups resulted in a number of themes. Only three will be discussed here; racism and discrimination, social justice and health services.

Racism and Discrimination

From the participants' perspective racism and discrimination was something that people felt, heard and saw because of their identity; their culture; the colour of their skin; the way they did things; their reactions, and/or their actions. Racism and discrimination was not only experienced when accessing the local hospital but when accessing any type of service locally. Participants described their experiences saying: "...*They (non-Aboriginal people) treat you differently*" "...*Look down at you, you know really degrading*" "...*Putting you down all the time*". They described how they were treated by the police and shop attendants: "...*Police pull up our black kids, empty your pockets empty your pockets, take your pants down*" "...*We're terrorists in our own country; the way we are being treated*" "...*Because of the dark skin they (shop attendants) followed her (my mother) around the store like she was going to steal something*". Participants believed that they did not have the same opportunities as non-Aboriginal people when seeking employment or welfare assistance "...*they (Centrelink staff) ask the black fellow for the Aboriginality*" "...*Because we're Murris we feel it and we know it. Those people (non-Aboriginal) might have the white skin but we've got the black skin and we feel it more*". Participants further described how seeking help from the local hospital often resulted in them being locked up and exposed to further acts of racism and discrimination such as "*being put up on assault, refusing and resisting arrest*", because of the influences (drug and alcohol) they had been under. There is strong evidence that systemic racism existed for participants in a number of life domains, resulting in reduced opportunities to access the societal resources required for good health.

Social Justice

Social justice is about being treated equally, having the same rights, access and opportunities, being shown respect and having all cultures embraced within the community. It is about being able to access whatever mainstream has to offer. Participants described how there are limited services available and accessible to the elderly, sick and disabled Aboriginal people within the community "...*We need homecare out here for the Aboriginal Elders and the sick people*" "...*There's no such thing out here, they don't believe in homecare*" "...*We've got no*

homecare services here to provide for our elderly” “...Respite is full up”. The community provides a variety of health and counselling services, however the Aboriginal community generally access the hospital and the Aboriginal medical services, in particular the stolen generation counselling services. “...We have suicidal problems here and we’ve still got them” “...Mental health services have been promised so much”. Participants stated they have a high level of crime occurring amongst their youth But while Aboriginal Legal services are available within the community they were very difficult to access given the level of crime, racism and discrimination exhibited by the police. Legal representation was even more difficult because of the perceived attitude and conduct of the Aboriginal legal aid officer: “...We only know it (about legal services and proceedings) when our children go to court. That’s the only time we see her (Aboriginal legal aid officer)” “...You go to court to take your children to the court, sit with them, whether they’re guilty or not, it doesn’t make any difference, they’re guilty” “...There’s no justice for Aboriginal people in this town, no justice whatsoever. You’ve got no chance here”

Health Services

Aboriginal & Torres Strait Islander people are more likely to access mainstream services in the event of a crisis instead of other community based services, which are unevenly and poorly distributed in rural and remote settings (Harper et al 2004). Participants stated that even though their community was small in comparison to urban cities, their problems or issues were more prominent. Participants stated that when they were seeking help there was a sense of rejection and refusal by those being approached to assist them in accessing the right services at the right time. For example “when asked for help no-one is there to help, nobody is willing and no-one will do it or help us do it?” Participants felt that living in the community or being well known resulted in the level of racism and discrimination increasing at the time of accessing mainstream services. Participants shared their experiences: “...You’re an Aboriginal person (if) you go there if you’re sick, you’ve either been drinking or you’ve taken drugs” “...There’s not enough training in the Dalby hospital on Aboriginal culture and how to talk to Aboriginal people” “...They (Aboriginal medical service) don’t do home visits where there should be home visits” “they (some community people) won’t access those places (Aboriginal medical service and hospital). They go to other townships (major hospital is an hour away) where people don’t know them because they don’t trust the people here that work in those medical centres (Aboriginal medical service) or the hospital” “...They (Aboriginal medical service) haven’t even had health checks yet and they don’t

advertise it” “...We’ve got the same problems as they have in the cities, but ours are more noticeable”. There are a number of private general practitioners available within the community and there have been several closed down over the years. At the same time non-Aboriginal people are now accessing services specifically designed for Aboriginal and Torres Strait islander people: “...Aboriginal people can’t get into to see their normal doctor...the white community are told to access the Aboriginal medical services because they bulk-bill and the white community has taken advantage of it” “There’s not enough (Aboriginal) services... . Participants stated that even though services exist and there are plenty of these being provided across the community they are not available to everyone.

DISCUSSION

A number of the changes occurring within the community are having a huge impact on the local Aboriginal people and are proving difficult for some people to handle because they have to compete against more barriers than other local people and new residents for jobs, services, and support. Participants identified that a high level of racism, discrimination and prejudice is experienced when accessing health, counselling and other services within the community. For instance when approaching the local hospital Aboriginal people feel they are being stereotyped because of their Aboriginal identity with assumptions being made that they have been drinking or taking drugs. Participants repeatedly suggested that they feel they are discriminated against in accessing health services including the risk of being locked up for alcohol related offences. They also experienced a level of prejudice when they accessed services generally within the community, a commonly held view shared by participants across focus groups. They believe that community health services are for the “*out of town people, like the cockies (non-Aboriginal people from properties)*” and people from smaller towns surrounding Dalby; stating that they themselves don’t use this service often. This perception was reinforced by staff from Stolen Generation counselling services, stating that “*some people (in the community) are aware that these services are for those who are from the community*” however simply don’t use these services. Participants repeatedly suggested that even though services exist they are not available to everyone in how they are described to be provided and services should be more available to community people. Participants often stated that when they were seeking help there was a sense of rejection and refusal. Participants stated — “*when asked for help no-one is there to help, nobody is willing and no-one will do it or help us do it?*”

CONCLUSION

Socioeconomic disadvantage experienced by Aboriginal & Torres Strait Islander peoples in Australia is linked with both historical and contemporary racism, colonisation and oppression. This study has shown that for the participants racism continues to exist and have an impact on their social and emotional wellbeing. For health services in particular to provide the services that are needed to address the health disadvantages that Aboriginal people experience, there is a need to overcome the negative perceptions that clients have and to instil a sense of confidence that the service will provide culturally appropriate service to its Aboriginal clients.

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Reference List

Australian Health Ministers 'Advisory Council (2004). Cultural Respect Framework for Aboriginal and Torres Strait Islander Health, 2004 – 2009.

Australian Health Ministers 'Advisory Council (2006). Aboriginal & Torres Strait Islander Health Performance Framework. D. o. H. Ageing, Australian Government: 1-190.

Cooperative Research Centre for Aboriginal Health. (2006). Program Statement: Social and Emotional Wellbeing. Darwin Viewed January 2008
<http://www.crcah.org.au/research/downloads/SEWB-Program-Statement-2006.pdf>

Garvey, D. (2000). A response to the Australian Psychological Society Discussion Paper on Suicide. *Australian Psychologist*, 32-35.

Grbich, C. (1999). *Qualitative Research in Health: An Introduction*. Allen and Unwin.

Harper C, Cardona M, Bright M, Neill A, McClintock C, McCulloch B, Hunter I, Bell M. (2004). Health Determinants Queensland 2004 Public Health Services. Queensland Health. Brisbane 2004.

Kahn, M. M. (1978). Mental health services by and for Aboriginals. *Australian and New Zealand Journal of Psychiatry*, 221-228.

Mouse, D. (2004). *Social and Emotional Wellbeing Framework: A National Strategic Framework for Aboriginal and Torres Strait Islander peoples' Mental Health and Social and Emotional Wellbeing*. Australian Government Publishing Services.

National Health and Medical Research Council (2005). Keeping research on track: A guide for Aboriginal and Torres Strait Islander peoples about health research ethics. Viewed May 2007.
http://www.nhmrc.gov.au/files_nhmrc/file/publications/synopses/e65.pdf

Radford, A. J. (1991). Social health among urban Aboriginal heads of households in Adelaide with particular reference to suicide attempts. *Aboriginal Health Information Bulletin*, pp. 15-25.

Swan, P. & Raphael, B. (1995). Ways forward: Aboriginal and Torres Strait Islander mental health policy: national consultancy report. Canberra: Australian Government Publishing Service.

Vicary, D. A. (2002). *Engagement and intervention of Non-Aboriginal Therapists Working with Western Australian Aboriginal People*. Perth: Curtin University.

Westerman, T. G. (2004). Engagement of Indigenous Clients in Mental Health Services: what role do cultural differences play? *Australian e-Journal for the Advancement of Mental Health*.